DOCUMENT RESUME

ED 276 920 CG 019 537

AUTHOR Cohen, George M.; And Others
TITLE Families: An Expanding Role for Professional Counselors. Proceedings of the Conference (San Antonio, Texas, February 1-3, 1986).
INSTITUTION American Association for Counseling and Development, Alexandria, VA.
PUB DATE Feb 86
NOTE 89p.; This publication was made possible by a grant from Shell Companies Foundation.
AVAILABLE FROM American Association for Counseling and Development, 5999 Stevenson Avenue, Alexandria, VA 22304 ($4.00).
PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Counseling Techniques; *Counselor Role; Counselors; *Family Counseling; *Family Problems; *Marital Instability; *Parent Child Relationship; *Youth Problems

ABSTRACT

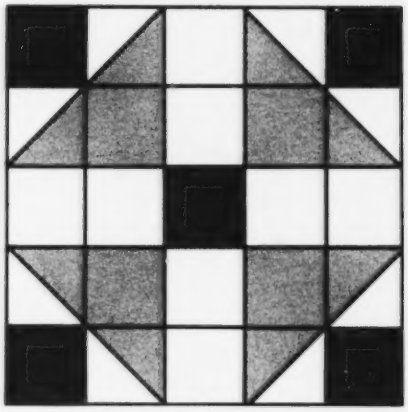
This document contains papers from a conference which targeted the needs and interests of counselors working with families. Individual papers in the book include: (1) "Economic, Social and Political Influences on Families" (Lynda Henley Walters); (2) "Family Structures and Stresses: A Counseling Perspective" (Edwin Herr); (3) "Cultural Diversity Among American Families" (Michael S. Nystul, et al.); (4) "Working with Families: A Demonstration" (Bunny Duhl); (5) "Impact of Work on Families" (Juliet Miller); (6) "Case Studies" (Patricia Ponder); (7) "Child Sexual Abuse" (Bob Rencken); (8) "Marital Separation" (Cyrus Stewart); (9) "Substance Abuse" (Ann Worth); (10) "Eating Disorders" (Pat Halvorson and Pat Neuman); (11) "Suicide" (Dave Capuzzi); (12) "Families and Unemployment" (Andrew Helwig); (13) "Disability in the Family" (Paul Power); (14) "Families with Aging Members" (Jane Myers and Barbara Shelton); (15) "Values Transmissions" (Judith Miranti); (16) "Communicating about Sex" (Kay Stritzel); (17) "Single Parent Families" (Rick Bruhn); (18) "Credentialing Issues for Marriage and Family Counselors" (David Brooks, et al.); (19) "Stepfamilies" (Frank Williams and Lynn O'Hern); (20) "Sex Roles" (James Winfrey); and (21) "Marriage and Family Assessment Instruments" (Norman Fredman). Also included are the Children, Youth and Families Survey, a 5-page bibliography, and the conference program. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED276920

Conference Proceedings

February 1-3, 1986
San Antonio



Quilt pattern: "Grandma's family"

CG 019537

Families:

An Expanding Role For Professional Counselors

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

Sharon Alexander

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

American Association for Counseling and Development

Sponsored by:

American Association for Counseling and Development

in affiliation with

- American College Personnel Association
- American Mental Health Counselors Association
- American Rehabilitation Counseling Association
- American School Counselor Association
- Association for Counselor Education and Supervision
- Association for Humanistic Education and Development
- Association for Measurement and Evaluation in Counseling and Development
- Association for Multicultural Counseling and Development
- Association for Religious and Values Issues in Counseling
- Association for Specialists in Group Work
- Midwest Regional Branch Assembly
- National Career Development Association
- Southern Regional Branch Assembly

This publication was made possible by a gift from:
The Shell Companies Foundation
Houston, Texas

BEST COPY AVAILABLE

FAMILIES: AN EXPANDING ROLE FOR PROFESSIONAL COUNSELORS

February 1-3, 1986

San Antonio, Texas

Conference Proceedings Prepared by:

George M. Cohen
Rose Cooper
Barbara Cox
Gary Kasey
Patricia Ponder
Kathleen Ricker
Sharon Alexander, Editor

Conference Planners:

Sharon J. Alexander, Director
Professional Development and Research, AACD

Frank E. Burtnett, Assistant Executive Director
Association and Professional Relations, AACD

ACKNOWLEDGEMENTS

The following people were instrumental in the formulation of the conference goals, objectives, format and content. They attended the Families Conference Planning Meeting, representing their divisions and regions: Shirley Brown (NAR), Niel Carey (NCDA), Cathy Gordon (SRBA), Wanda Hickman (AMCHA), Dorothy Jenkins (ASCA), Carolyn Lovett (MRBA), Aaron Stills (AMCD), Jean Thompson (AACD), Craig Washington (ASGW), Ted Wilson (AHEAD), James Winfrey (ACES). Thanks also are extended to all those who suggested or recruited speakers and presenters as well as those who contributed their expertise through their participation. Geraldine Mullins was most helpful in providing on-site support. Finally, warmest thanks to Jacquelyn T. White who typed the many drafts of these proceedings.

TABLE OF CONTENTS

Introduction 1

Economic, Social and Political Influences on Families... Lynda Henley Walters 3

Family Structures and Stresses: A Counseling Perspective... Edwin Herr 8

Cultural Diversity among American Families... Michael S. Nystul, Augustine Baron, Dorothy Jenkins 13

Working with Families: A Demonstration Bunny Duhl 17

Impact of Work on Families Juliet Miller 22

Case Studies for your consideration Patricia Ponder 25

FAMILY PROBLEMS AND EFFECTIVE APPROACHES

Child Sexual Abuse... Bob Rencken 33

Marital Separation... Cyrus Stewart 35

Substance Abuse... Ann Worth 38

Eating Disorders... Pat Halvorson and Pat Neuman 41

Suicide... Dave Capuzzi 43

Families and Unemployment ... Andrew Helwig 46

Disability in the Family... Paul Power 49

Families with Aging Members... Jane Myers and Barbara Shelton 51

FAMILY DEVELOPMENT: COMMON STAGES AND FACILITIVE PROGRAMS

Values Transmissions... Judith Miranti 53

Communicating about Sex... Kay Stritzel 55

Single Parent Families... Rick Bruhn 57

Credentialing Issues for Marriage and Family Counselors... David Brooks, Rory Madden, Richard Wilmarth 59

Stepfamilies... Frank Williams and Lynn O'Hern 63

Sex Roles... James Winfrey 65

Marriage and Family Assessment Instruments... Norman Fredman 66

Children, Youth and Families Survey 67

Bibliography 70

APPENDIX A: Conference Program 75

INTRODUCTION

In January, 1985, the American Association for Counseling and Development sponsored a conference to address the role of counselors in contributing to educational excellence. Participants responded so positively to this conference that AACD decided to offer another one, targeting the needs and interests expressed by many counselors for further attention to working with families. For decades we have treated clients for their problems. As our field has evolved, we have seen the importance of working with individuals in the context of families and groups. The entire family is often impacted by issues such as unemployment, substance abuse, or divorce. In addition, counselors can work with families on developmental issues to prevent problems from arising.

Counselors in many different work settings are concerned about treating families--mental health, school, rehabilitation and career counselors to name just a few. Counselors can assist not only those families who are troubled but also those who are facing typical family development issues.

To assist AACD in planning this conference, representatives of nine divisions and two regions attended a meeting in May, 1985, to articulate the purposes of the conference, establish the format, focus on priority topics and identify potential speakers. With this input, "Families: An Expanding Role for Professional Counselors" was underway.

The conference had three specific purposes: (1) to expand participants' knowledge about providing counseling services to families; (2) to increase participants' skills in working with families; and (3) to network with other professionals. According to the evaluations by participants, the conference was very successful in meeting these goals.

"Families: An Expanding Role for Professional Counselors," held February 1-3, 1986, in San Antonio, Texas was attended by 139 participants from 27 states and one foreign country. The speakers were informative and dynamic, offering their expertise to assist counselors in their work with families. Of particular interest were case studies that challenged participants to plan their own interventions with families and a live therapy session with a real family.

Because the information shared at this conference is of interest to so many counselors, AACD has prepared these Proceedings for dissemination to a broader audience. These summaries highlight key points of each session. Although they cannot capture a speaker's dynamism or participants' contributions, we hope they will be informative to all who are concerned about meeting the needs of families.

P.J. McDonough
Executive Director

ECONOMIC, SOCIAL, AND POLITICAL INFLUENCES ON FAMILIES

Lynda Henley Walters
Associate Dean for Instruction and Research
Associate Professor of Child and Family Development
University of Georgia

It can be difficult to understand families because we tend to interject our own family experiences into our understanding of other families. I am going to present some key facts about families, mostly from the Statistical Abstracts of the United States.

First, what are some general comments that can be made about families? There is tremendous variability in families. The strengths and weaknesses of families are products of the combined influences of family members and external influences. Part of the problem with understanding families is that it is difficult to observe, much less understand, the diverse interactions of factors that affect families. Life is complex and not always what it seems. The real facts about families often stand in sharp contrast to what we are led to believe about families.

A Few Economic Facts

1. Middle class families have more money to spend than ever before in history. Considered in constant dollars, after-tax income increased about 32% between 1965 and 1983. However, during the 1965-1983 period, costs increased as follows: durables = 80%, nondurables = 30%, and services = 50%. Clearly, we may have more money, but it isn't going as far.

2. Owning a home is associated with having roots, even though the residence may not be considered permanent. The cost of home purchase and ownership more than doubled between 1970 and 1980. In the past, we thought that the cost of home ownership should not exceed 25% of gross income. Using that criterion, 38% of families could afford to own a home in 1965; only 3% could afford to own a home in 1981.
3. Families are struggling with more debt than ever before, and they are experiencing stress related to over indebtness. Although more money is being saved than in the past, debt has increased twice as much as savings.

Social Influences

1. The population of the United States has changed from rural to urban at a rate of about 10% every twenty years since 1890. In 1890, 33% of the population lived in urban areas; in 1970, approximately 73% of the population lived in urban areas. Concommitantly, the size of the population has increased at an accelerated rate. As density increases, the sense of community may decrease. In a recent study by Yankelovich, Skelly and White, 50% of the respondents said they "hungered for a sense of community." In 1973, the proportion was only 30%.
2. The number of persons over 65 years of age has increased. This means that many middle aged adults provide physical, psychological, and/or financial care for their parents. Approximately 46% of persons over 65 have some physical

limitation, and about 39% have a major physical limitation. Resources of retired persons do not keep pace with inflation. More women are living 15 years beyond retirement, and if they do, with an 8% inflation rate, their economic resources must nearly triple to maintain the same standard of living.

3. More women are working. In 1890, approximately 18% of women worked; in 1980, nearly 52% were employed. Still, the attitudes of many do not support the notion of women working.
4. The increase of women in professional and technical careers has increased only about 3% since 1950. The vast majority of women still work in clerical positions (approximately 14,000,000 in 1979 compared to 2,000,000 in managerial/administrative and 6,000,000 in professional/technical).
5. More women who have young children are working. In 1950, about 12% of women who worked had children under 5 years of age; in 1979 this percentage was about 45%. The percentage of working women who have children between the ages of 6 and 17 was about 28% in 1950 and 62% in 1979.
6. Household size has decreased, in part as a result of divorce. The rate of divorce is increasing faster than is the rate of marriage; the proportion of married couples decreased between 1970 (72%) and 1983 (64%).

Political Influences

Political influences on families are most difficult to specify. Opinions regarding the political climate and specific actions are dependent to a large degree on societal attitudes.

It is important to recognize that in addition to being influenced, families influence the political climate. Part of the intrusiveness of government into families is partially the product of the increase in the number of individuals who seek mediation and arbitration through the legal system for family problems.

Today much lip-service is paid to the importance of families. Yet, specific legislative actions are contradictory and vulnerable to disjointed preferences of special interest groups. Some actions within the past few years include the following:

1. Concern for children has been demonstrated through the reauthorization of the Child Abuse Prevention and Treatment Act of 1974. An emphasis was placed on out-of-home care, sexual abuse/pornography, and medical abuse of infants. Funding for family violence programs that also would reduce the rate of child abuse was cut from the 1984 budget. Other programs for special needs children included after-school programs, funds for foster care, and adoption.
2. Concern for families has been demonstrated by tax benefits to families although these have not been nearly enough to make a difference in the disposable income of most families. In low income families who are least affected by tax advantages, the situation is even more confusing. For example, an effort has been made to redefine poverty so that non-cash

benefits are counted as part of income, e.g., housing subsidies, food stamps. At the same time, an effort has been made to reduce the limits on the ability of a family to draw AFDC benefits.

In such a political climate, it is not suprising that about 60% of the respondents in a survey said that they do not believe that the people running the country care about them and that 70% said they cannot trust the government to do what is right (Harris Survey and Institute for Social Research, University of Michigan).

For those of us who work with and teach about families, the important points to remember seem to be that (a) the diversity among families is increasing and (b) families are both affected by and affect their environment. Families are not the victims of society; families participate in the construction of their role in society. This does not mean that our society is as supportive of family life as it should be. It isn't. However, we should remember that family life patterns have been evolving for centuries, and we appear to be in an active period of transition today. The fact that families may be different today than they were in past decades does not necessarily mean that they are worse.

Our opinions are colored by our own, idiosyncratic experiences. Life is complex and is not always what it seems. We are as

vulnerable to influence by the mass media as are the families we work with. What families need from professionals is more objectivity and more compassion.

FAMILY STRUCTURES AND STRESSES

Edwin Herr
Professor and Head
Division of Counseling and Educational Psychology
The Pennsylvania State University

Counselors need a repertoire of intervention strategies which may be applied with individuals, groups and families. At this conference the focus is on the family, a unit which provides the content, the context and often the instrument for counseling. The family structure defines the actors who need to be involved in counseling and the context in which roles and relationships are played out. Family stressors are the presenting content for counseling.

Demographic changes among American families reflect not only the changes in structures but also potential stressors. Among the notable changes in family structure are:

(1) more married couples who postpone having children;

(2) a divorce rate of almost 40%;

(3) among children under age 18, 50% with two working parents;

(4) 35% of parents supplementing their own child-care with other caretakers;

(5) female-headed households comprising 15% of American families;

(6) approximately 4 million latch-key children; and

The trend in family sructures over the past two decades has been toward increasing pluralism. As compared to the conventional, intact nuclear family, the family forms which have shown the largest increases are those which directly relate to increases in divorce, dual work and dual career families, single-person households, and nonmarital cohabitation.

Among the categories of nontraditional family forms identified by Macklin (1980) are: nonmarital cohabitation, voluntary childlessness, binuclear (divorced, with shared custody), stepfamily, same-sex intimate relationships, and multi-adult households.

The more open the family system, the greater the degree of independence and autonomy experienced by individual family members and the more likely their ability to function in a self-directed manner. The more closed the system, the greater the difficulty in differentiation, individualism, and separation experienced by the family members.

Since World War II, Americans have experienced wave after wave of significant value shifts: equality and equity, quality of life versus materialism, and changes in religiosity, sex roles, sexual freedom, women's awareness and minority pride. Such changes have affected social perceptions of family units and the individuals within each family.

In addition to the value and structure changes, societal changes have also had an impact on families. Family relationships between schools, social service agencies,

employers, the legal system and government have evolved. In some cases, these entities have assumed some responsibilities previously allocated to families. In other cases, they have impeded families and added to their stress.

Family Service America, a membership organization for social service organizations, surveyed their affiliated agencies and found that among the most frequent stressors of the families they served were unemployment, single parenting, family violence, incest, less government assistance, divorce and remarriage, blurred male and female roles, depression and loneliness, aging, pregnant and parenting adolescents, substance abuse, and family communication problems.

A family's ability to accurately perceive stressors and then to adopt coping behaviors determines its level of functioning. To assist them in this process, family counseling has been advocated in schools, in rehabilitation settings, in employee assistance programs, in community agency settings and in virtually every other context in which counselors are engaged. Family counseling has increasingly become the preferred treatment of choice for a wide variety of problems, e.g., child abuse, learning problems, juvenile delinquency, adolescent eating disorders, and chemical dependency.

Several major approaches to family counseling have evolved and are briefly summarized below.

Structural Family Therapy focuses on how the subsystems by which families are comprised are connected. Intervention focuses on

promoting structural viability by establishing a clear generational hierarchy and promoting semipermeable boundaries among subsystems. Minuchin (1974) and his associates are the primary progenitors of this approach.

Strategic Family Therapy includes a blend of Minuchin's work with communication theory (Haley, 1976) and paradoxical relabeling (Selvini et al., 1980; Walzlawick & Weakland, 1977).

Experiential Family Therapy is an existential orientation to having families experience their own irrationality and "craziness" (Whitaker, 1977).

Social Learning Approach combines operant learning and social exchange theories, general systems theory and attribution theory. It focuses on interaction patterns, problem-solving and other specific behaviors in the family system (Vincent, 1980).

These approaches are not mutually exclusive or exhaustive of all approaches, nor does any one of them have a clear-cut advantage across different types of family problems. In their individual ways, each of these approaches attempts to treat the family as a system rather than treating a symptom which the family experiences collectively or one member manifests. Clinicians and researchers are trying to determine which approach or mode of treatment is likely to be most effective for what type of family or group of clients experiencing which sorts of problems. In addition to treatment, family counseling is also generating preventive and enrichment programs designed to avoid major stresses and crises by promoting structured communication

skill building and other forms of relationship enhancement programs.

Major questions for the counseling field are: How and where will counselors receive the training they need to conceptualize and implement family counseling? Will such training be random or systematic? Will it be linked to other emphases in counselor education or stand independently from them? A related issue is how behavior is viewed in terms of its locus and purpose. In contrast to individual counseling where many counselors have viewed psychological difficulties as intrapsychic matters, family counseling shifts the focus from symptoms to strategies which people use to cope with their relationships with others. Such approaches are based on the premise that psychological maladjustments are social and interpersonal, rather than biological or intrapsychic (Allen, 1975). The notion of a family system suggests that there is a chemistry of relationships and interacting subsystems in which matters of communication, cohesion, adaptability and resource management come together in unique ways. Finally, it is essential to remember that "Family structures are not simply personal arrangements among family members. They are manifestations of the values of the cultural group to which the family belongs" (Aponte, 1982, p.8). If counselors are to assess, treat, and communicate with a family effectively, they must be sensitive to the cultural roots of the family and of themselves. Ultimately, family counseling requires the counselor not to be an anthropologist or sociologist, but

rather one who appreciates the variability in values,transitions, and patterns which become mediators of family systems and, indeed, of the effectiveness of counseling.

CULTURAL DIVERSITY AMONG AMERICAN FAMILIES — NATIVE AMERICANS

Michael S. Nystul
Associate Professor
Eastern New Mexico University

Dr. Nystul discussed his work with Navajo Indians. He cited several statistics that reflect common problems among Native Americans.

- 40% of all Navajo deaths are behaviorally caused (accidents, alcohol, suicide).
- 1 out of 3 Indians will be jailed at some time during his/her lifetime.
- 1 out of 2 Indian families will have a relative die in jail.
- The life expectancy of Indians is 44 years.
- The average income per year for the Indian family is about $2,000.
- Between 40% and 80% of the tribal members are unemployed.
- Suicide is seven times the national rate.
- Alcohol-related deaths are twenty times the national rate.

These facts illustrate some of the special concerns for counselors who work with Navajo Americans.

There are major value differences between Indians and Anglos. Indians tend to cherish humility, sensitivity and creativity while Anglos tend to value competitiveness, analytical ability and drive.

In working with Native Americans, Dr. Nystul emphasized that the counselor needs to recognize the Indians' strong desire to live in harmony with the environment. Other guidelines include:

1. Be humble, curious (interested), sincere and genuine.
2. Be warm and enthusiastic in your welcome.
3. Use an action-oriented approach (short range, concrete goals).
4. Use reflective listening.
5. Be flexible. (Therapy may involve longer sessions and incorporation of the Indians traditional ways of handling problems).
6. Allow yourself to get excited and to learn.

Navajos, of course, do not represent all Native Americans. Tribes may vary in their values and outlooks. This information on Navajos is presented to raise awareness about possible cultural differences among Native Americans and their implications for counselors.

CULTURAL DIVERSITY AMONG AMERICAN FAMILIES — HISPANICS

Augustine Baron, Jr.
Director of Training
University of Texas Counseling and
Mental Health Center

Dr. Baron discussed key characteristics and moderating variables of Hispanics. Some of the key characteristics are:

- Patriarchal, extended families
- Catholic religion
- Cooperation vs. competition
- Spanish language dominance.

These characteristics are modified by such variables as:

- Nationality
- Socio-economic status - a major modifier
- Regional differences
- Urban vs. rural upbringing.

Dr. Baron discussed the concept of machismo. He acknowledged that if machismo is equated with chauvinism. then the concept is viewed negatively by many Hispanics. However, within the Latino cultural context, machismo has many positive connotations including courage, bravery, generosity, leadership, respect, courteousness, and sensitivity. In the Latino sense, then, the concept is closer to the notion of chivalry and gallantry than chauvinism.

Another concept discussed was the idea of a "link therapist." This is a person in the family who can take the therapeutic message back into the family. This person is usually not the most nor the least acculturated. Link therapists have been used successfully in family counseling and are only one example of how counselors can adapt to work with Hispanics.

CULTURAL DIVERSITY AMONG AMERICAN FAMILIES — BLACKS

Dorothy Jenkins
Director of Guidance & Counseling
District of Columbia Public Schools
President, ASCA

Dr. Dorothy E. Jenkins noted that historically black family life has been problem-oriented. Until relatively recently, almost all studies of black family life have concentrated on the lower income strata of the group while ignoring middle class families or even stable poor black families (Staples, 1984). The media reinforced this stereotypic perception in the recent documentary, "The Vanishing Family: Crisis in Black America."

Of course, many black families are victims of poverty, unemployment, and single parenthood. The consciousness of Americans is being raised about ghetto life and the massive economic drawbacks of blacks. Blacks throughout the nation are joining to lower the teenage birthrate, increase training opportunities, build positive self-images, turn around hopelessness and change the tomorrows.

Contrary to the recent reports, Dr. Jenkins noted that the traditional black family is stable. Together parents have raised their children, imbuing them with determination to get an education, to secure a good job, to raise a generation of better educated children, to seek success and to enjoy what they perceived as the "good life."

Dr. Jenkins stated that an analysis of the black child's perceived-self reveals constant exposure to negative stimuli. Our students are bombarded daily with demeaning social messages. The effective guidance counselor has an opportunity to become a "significant other" and break this self-defeating cycle of negative self-perception, poor performance, and low self-concept.

Guidance counselors must de-emphasize weaknesses and help black children recognize and use their unique strengths. Black children desperately need positive counseling that contributes to their self-understanding and self-acceptance. Given the serious economic conditions in America, structuring effective, powerful, positive counseling climates in schools is extremely urgent.

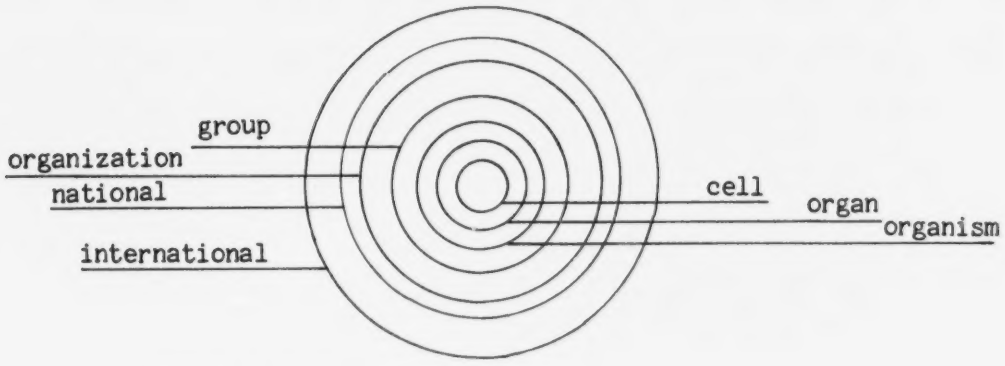
WORKING WITH FAMILIES: A DEMONSTRATION

Bunny S. Duhl
Co-Director
Boston Family Institute

When considering how a therapist works with a family, it is important to understand the frame of reference that the therapist uses to approach the situation. Because a therapy session presents much more material than a therapist can address, a conceptual framework is vital in structuring what topics will be addressed. The thought processes within the therapist and the action that actually takes place often differ significantly.

Dr. Duhl explained that she looks at a family situation within a general systems framework which holds that every aspect of life affects us and the relationships that we have. The

illustration below depicts a number of concentric circles revolving around and affecting the individual. These seven concentric circles start at an individual's cell level and move out to the organ, the organism, the group, the organization, the national level and the international levels.



What happens within the cell or the organ, such as cancer or blindness, affects the entire individual and the family of which he/she is a part. In moving from a single individual to the more complex layers of society, it becomes apparent that all systems are represented in the individual's responses to the environment as well as in his/her capacities for survival within the environment. Survival is a process of creative adaptation which enables one to get along with other people and systems.

Family, neighborhood, peers, religious institutions and schools are environments for individual development. Things

occurring at different societal levels implode upon the family. On the national level, social legislation such as social security, Head Start, and welfare affects both the family and the individual. At the international level things that happen in the world around us influence the individual, the family, the community, and the nation. One example is the impact of the change in oil prices on what we pay for gas as well as on the loss of jobs for those in the oil industry. Television brings us information instantly, making national and international occurrences immediate. A timely example is the trauma created by the destruction of the Challenger Space Craft.

It is important for a counselor working with a family to understand where the focus should be placed and how much emphasis should be given to certain issues. Some problems, of course, are not truly family problems, such as child/school problems.

Because each person sees an issue from a different vantage point, the therapist has a complex task. In addition, low self-esteem inhibits change. The counselor must be able to accept each person wherever he/she is and to understand his/her view and "story," given each one's age, stage, and position, in order to help each move to a more adaptive place.

According to Dr. Duhl, the three major issues in therapy are self-esteem, personal autonomy, and connectedness. People struggle to feel good about themselves, to feel competent and confident, and to be connected with others in ways that also

feel good. The therapist's job is to help individuals and families deal more effectively with these issues.

For effective therapy, family members must be aware that there is a need to change something in the family and that each has a stake in it in some way. Change does not take place when family members do not admit that there is a problem. The change must fit the inner coherence of family members as well as the external, interactive context or it will not last.

When a counselor approaches a therapeutic situation, he/she needs to remember that each individual member of the family has a past, present and future. It is necessary for a therapist to learn the values and beliefs of individual members and their relationships with others. Each person's past history influences his/her perspective and behavior. Suggesting change or updating raises the question of what it will be like in the future without a known, old pattern. People have difficulty imagining what has never existed before. It is necessary to be aware of what is being brought into the counseling situation, where each individual is at the current moment, and the fears of uncertainty.

The counselor's task is to make it safe for people to risk new behaviors and attitudes. People feel safe when they believe the counselor is interested and concerned about them. and when they feel known for their idiosyncratic sense of self, their contexts. and life history. It is important for the counselor to speak to each person in his/her own "language of impact," using images and metaphors from that person's life in talking with

him/her. When people feel known for who they are, they can more easily shift positions to "try on" a new behavior or attitude. Duhl provided this overview of her theoretical approach to help conference participants understand how she works with families.

Before the counseling session with the family began, Dr. Rick Bruhn shared a brief summary of the family's issues, his work with them, and his questions for Dr. Duhl. Then conference participants viewed a live family therapy session televised from the counseling room to the conference room. Dr. Duhl conducted the session as a consultant to the family's therapist, Dr. Bruhn.

The importance of history, context and personal images was revealed in this family session. The mother and her two teenagers had moved to Texas and the mother was now married for the third time. The husband, also thrice married, had no previous children and did not want to be a father to her children. Yet mother imaged a "normal family" unit. Her son and daughter were thus caught, away from their "real" home, being wanted/not wanted; mother was caught between husband and children; and stepfather was caught wanting a wife without children.

Among the techniques Dr. Duhl used during the session was a "magic wand" passed to each family member to make any wishes for himself/herself and for the family if each could have anything he/she wanted. Family members' responses gave a clearer picture of the diverse and conflicting wishes and issues ongoing at the time. Family sculpture, a restructing activity, was also utilized by Dr. Duhl. The audience was able to observe how this

particular technique changed the involvement and the relationship between and among family members.

Before concluding the family therapy session, Dr. Duhl "returned" the family to the ongoing therapist. In doing so, she gave feedback to the therapist and the family about what she saw and felt in her consultation with them and indicated directions in which the therapist could continue to work.

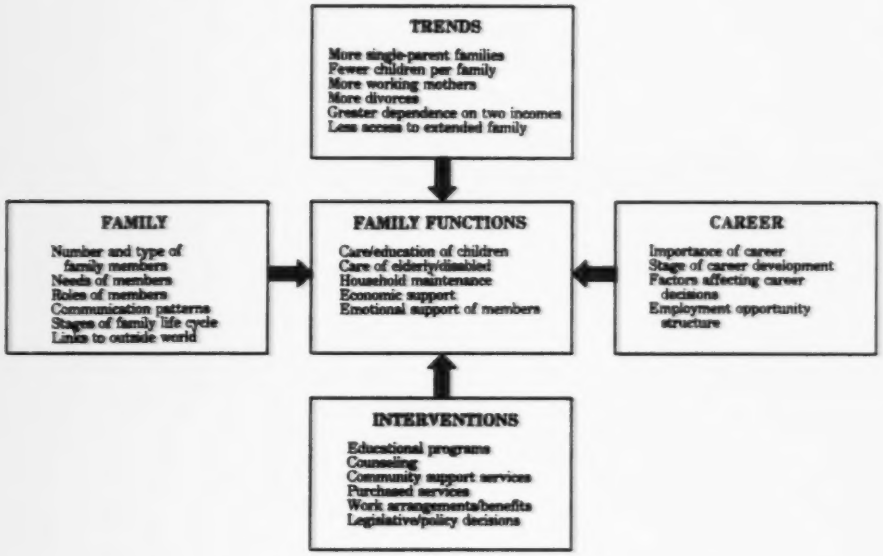
After viewing the family therapy session, conference attendees were able to discuss interventions undertaken by Dr. Duhl. During this session she explained some of her hypotheses, her reactions to each family member's viewpoint and how her systems perspective helped structure which issues she focused upon.

THE IMPACT OF WORK ON FAMILIES

Dr. Juliet Miller
Associate Director for Information Systems
and Director of the ERIC Clearinghouse on Adult,
Career and Vocational Education
National Center for Research in Vocational Education
The Ohio State University

Over the last several years changes in the family structure, the economy, and the status of women have created pressures within the family and have redefined work and family roles. Previous career development programs have generally not focused on the family-career connection. Too often personal career decisions have been made without considering their impact on all family members.

Dr. Miller has developed a family-career connection model with the major family functions at its center. The model illustrates four components that influence the family. These components are demographic trends, the structure and roles within a family, the career and the stages of development, and interventions or processes that can be used for working with people in career development.



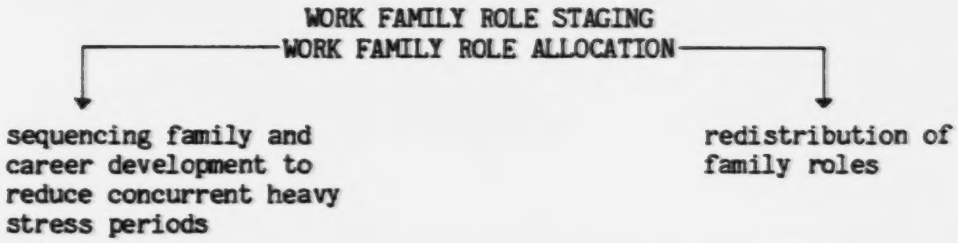
Both family and career can place heavy demands on the individual and it can be especially stressful when heavy family demands occur at the same time as heavy career demands.

Dr. Miller divides family stages into four major parts: the pre-school phase, the school-age phase, the post-parental phase and the aging parents phase. Similarly, development flows through the stages of exploration, establishment, maintenance, and decline. A person in the establishment and/or maintenance

BEST COPY AVAILABLE

phase of career development who also has school-aged children is in a very stressful situation.

Dr. Miller presented career guidance strategies for working with families in resolving any problems related to career development and family. These strategies would include the development of material to communicate career information to the family, negotiation about family roles, and sequencing of family and career to avoid the stresses caused by the coincidence of demanding family and career stages. Career development programs should provide such activities as role-playing simulations for men and women to personalize future trends, and awareness experiences for parents to increase their understanding of merging career and family role options, as indicated below.


WORK FAMILY ROLE STAGING
WORK FAMILY ROLE ALLOCATION
sequencing family and career development to reduce concurrent heavy stress periods
redistribution of family roles

Individuals should also be aware of needed social policy changes. Major concerns include the need to provide more financial assistance for child rearing and child care, to encourage the equitable sharing of tasks between men and women, and to create a better balance between work and family.

Clients and their counselors should be aware of current trends and their implications for individuals and their

families. In making decisions the stages of family and career development should be assessed. The counselor should know more than one strategy in dealing with any problem related to career development and the family, and both counselor and client should be cognizant that barriers can hinder the development of a career and a fully functioning family.

CASE STUDIES

Dr. Patricia Ponder
Associate Professor
Department of Counseling & Guidance
East Texas State University

The case study process was utilized to provide an opportunity for participants to integrate and apply the information received from conference speakers and to share their individual expertise with one another.

The audience was divided into work groups and given one of four fictional case studies to address. A worksheet was provided which included the following categories: (1) further information, (2) hypotheses, (3) goals, and (4) counseling strategies.

Each small group selected a reporter who relayed the information from the small group to the larger audience. Dr. Ponder facilitated this process and provided additional commentary for each case. Each of the cases follows with a brief summary of the participants' comments. The information is not intended to be all inclusive, but rather an example of the work which took place.

CASE STUDY #1

The Starks family is referred to counseling by the elementary counselor for "preliminary signs of child abuse." Their sons, Jeremy, age 8, and Jason, age 6, have reportedly come to school with numerous bruises and welts which, for the most part, go unexplained.

Mr. Starks states in the first session that they are "a common, ordinary family, with no big problems." He describes Jeremy as "lazy" and Jason as "rebellious." When questioned about these labels he explains that he has difficulty getting Jeremy to "do his jobs," i.e., mow the lawn and deliver his papers; and Jason has recently taken up "swearing." Mrs. Starks offers little information during the session, often deferring questions to her husband.

Further Information - (This category includes additional information that a counselor might need to know to be of help to the family.)

Is child abuse occurring? Other forms of abuse?

Do the parents have unrealistic expectations of the children?

What are the parenting styles like?

What is the mother's role in the family? The father's role?

What is the status of the marital dyad?

Hypotheses - (These include "hunches," educated guesses, or theories related to the family system. Hypotheses are validated or released depending upon information from the family.)

Parents lack information pertaining to nurturing and effective parenting.

Parental dyad consists of a dominant father, passive mother.

Mother may have physical problems and/or depression.

Children's behavior is developmentally appropriate.

Child abuse is present. Father is physically abusive, mother colludes out of fear or lack of knowledge related to effective communication and/or parenting skills.

Goals - (These may include family, individual and counselor goals.)

Determine if abuse is present. If so, intervene.

Provide information on age appropriate-behavior.

Provide information related to effective parenting.

Strengthen family subsystem.

Strategies - (These include specific techniques and/or information.)

Develop a contract with family concerning abuse and its cessation.

Establish rapport with individual family members by utilizing bonding skills.

Strengthen subsystems through use of homework assignments, family structuring, modeling, explanation.

Determine the philosophy of child-rearing of the family and present a parenting style in line with the family's philosophy. For example, if the family has an autocratic philosophy, a behavioral model may be effective. If the family has a democratic philosophy, an Alderian approach may be utilized.

Play therapy may be used with the children, perhaps ultimately filial therapy.

CASE STUDY #2

Susan Jones comes to counseling for "help with her children." She states she "has had it" and is "at the end of her

rope." Her two sons Ryan, 16 and Michael, 14, reportedly "hate each other and fight all the time." Although Michael is younger, he is physically larger and stronger than Ryan. Their latest battle left both of them bruised and bleeding.

Susan works the 3-11 shift at a local restaurant as a waitress and has become frightened at the thought of leaving the two of them alone in the evenings. Three times last month she stayed home from work "to referee."

Susan has been a single parent for the past seven years and until last year had not dated or spent time with a man. Recently she has begun to consider marrying Seth, the man she's been seeing for a year. She is considering asking the boys for their permission and opinion concerning the marriage.

Further Information

How long has the fighting been going on? When did it first occur?

What has Susan tried?

What is Seth's role in the family?

What are Ryan's and Michael's thoughts and feelings about Seth? About their mother's relationship with him?

What is the role of the biological father?

What is the role of each son in the family?

Hypotheses

Susan is unsure of her parenting skills and authority.

One or both of the sons has been functioning as a surrogate parent and/or partner.

The boys are competing for power in the family.

The boys are acting out in response to the change in the family system.

The boys fear losing their mother to Seth.

Goals

Facilitate expression of thoughts and feelings of family members.

Facilitate integration of new person (Seth).

Clarify roles within the family system.

Support Susan as the parent in the family.

Gather information related to the boys' social support system(s), and strengthen these systems if necessary.

Strategies

Utilize active listening with individual family members.

"Normalize" family's behavior by delineating family's transitional state.

Reframe boys' behavior as a way of keeping the family together.

Provide stepfamily information.

Reassure children of their position and roles within the family.

CASE STUDY #3

John and Mary Curtis come to counseling with their three children. They have been married 18 months; Mary has one child. Jerry, age 5; and John has two children, Robert, age 11, and Cynthia, age 15. Recently two families in the neighborhood came to John and Mary reporting that Robert has been attempting to fondle the younger neighbor girls. He was also caught exposing himself to two older teenage girls. John expressed his shock at this news, reporting that his children have been "perfect

models," always getting along with everyone, including each other. They have been virtually inseparable as friends; "sharing the same room, spending leisure time together, even sleeping together." John and Mary each spent several years as single parents with their respective children prior to their marriage.

Further Information

How are individual family members reacting to the current family situation?

What are the roles of the non-custodial parents?

What is the status of individual family members with outside friends and support systems?

Is there a history of sexual abuse (physical, social, emotional)?

Is there an incestuous sibling relationship?

Hypotheses

Robert has been a victim of sexual abuse.

Family has diffuse boundaries between subsystems (i.e., spousal, parental, sibling).

Robert may be acting out due to his changing role in the family constellation.

Robert may be expressing the underlying frustration of the stepfamily which has heretofore been living in a state of pseudomutuality.

The "fantasy" stage of the stepfamily has been eroded by reality and the stage of conflict and conflict resolutions is becoming apparent.

Goals

Determine if sexual abuse is present.

Stop any sexual abuse, if occurring.

Delineate family subsystems.

Give information pertaining to the stages of stepfamily living.

Supply options for family structuring and roles.

Explore the possibility of differentation between Robert and Cynthia. Encourage peer relationships.

Strategies

Give information concerning appropriate sexual behavior, family roles and family responsibilities.

Provide opportunity for realignment of boundaries through the use of genogram, family structuring, homework assignments, information.

Affirm each family member's place in the new family by talking about their individual uniqueness and importance to the family's functioning.

Give information pertaining to the importance of the spousal dyad in the stepfamily.

CASE STUDY #4

The Hanson family is referred to counseling for follow-up after Mr. Steve Hanson has been released from residential treatment for alcoholism. Steve has recently begun to attend AA; Sharon, his wife, now attends AlAnon; and the children Ron (17) and Sheena (15) attend Alateen.

Ron begins the session by explaining why he and his parents and sister have come: "We need to get back to acting like a real family." Sharon agrees and supports Ron. Steve and Sheena both sit quietly throughout the session. Steve is crying silently at times and Sheena mostly is scowling at Ron.

Further Information

Is Steve still drinking?

How does counseling fit into their individual experiences in AA-related groups?

Why is the family here? Is this a forced referral?

What did Steve's residential treatment consist of?

How much information does the family have in relation to alcoholism and its family dynamics?

Hypotheses

Father has abdicated his role of parent, perhaps spouse.

Ron has become a part of the spousal and/or parental dyad.

The family is divided into at least two sub-groups: Sharon and Ron, Steve and Sheena.

Family members have been "enabling" Steve in his dependent role.

Goals

Cease substance abuse.

Discuss options for Steve pertaining to alternative methods of coping.

Build upon AA model of recovery.

Strengthen family subsystem.

Restore authority of parental dyad.

Affirm family for staying together, working together.

Strategies

Utilize AA information.

Support AA model.

Introduce positive coping mechanisms, such as assertiveness training, effective communication exercises, affirmations, thought stopping, cognitive restructuring.

Encourage activation of support groups such as extended family members, friends, church members, and organizations.

Teach parenting skills.

Give homework assignments to strengthen marital dyad. Perhaps meet with couple separately on occasion.

Support individual family members with active listening and affirmation while family realigns roles and responsibilities

Give information pertaining to roles and responsibilities of individual family subsystems.

Case Studies Summary

It is important to reiterate that the responses to the case studies were not intended to be all inclusive; rather they are examples of questions, hypotheses and approaches one might take throughout the counseling process. Information and strategies would naturally depend largely upon the progression of the counseling and input from the family members. The case study process was an experiential exercise designed for integration and sharing of information by conference participants.

CHILD SEXUAL ABUSE

Bob Rencken
Executive Director
Arizona Counselors Association

It is estimated that approximately 20% to 30% of the children in the United States today will be victims of some kind of molestation or sexual abuse by the time they reach the age of majority. The trauma of victimization, poor self-esteem and poor sexual functioning are likely to plague them in adulthood.

The terms **sexual abuse** and **sexual molestation** are generally used interchangeably. The two predominant forms of molestation and/or abuse are intrafamilial sexual abuse (contact between family members), and pedophilia (contact with non-family members).

Approximately 75 out of every 100 incidents of sexual abuse or molestation of children are intrafamilial. Intrafamilial abuse is a result of a family problem that is manifested as sexual behavior. An adult who is involved in intrafamilial abuse generally has had sexual relationships with adults as an adult. In contrast, the adult pedophile has poor or no sexual relationships with adults. A pedophile has a sexual fixation on children. In treatment, the prognosis is better for someone who is an intrafamilial abuser and recidivism is lower than for a pedophile.

A comparison can be made between the feelings of the abuser in either a case of incest or pedophilia. At first the incest offender denies that the incident actually took place. This denial is replaced by guilt which helps to motivate the abuser into treatment. The pedophile, on the other hand, denies responsibility and believes that he really loves children and therefore has done them no wrong. The reality, however, of the pedophile abuser is that the pedophile does what he does for the benefit of himself and not for the children.

At least sixty percent of all intrafamilial abuse takes place between children and stepfathers or live-in boyfriends. It is a problem of poor intergenerational boundaries. Within the family, sibling sexual abuse is also prevalent but there is a problem with calling it abuse if there is no significant age discrepancy between the siblings.

People who become involved in sexual abuse of children tend to be passive-agressive, dependent personalities with immature feelings and inadequate personality development. In many cases they are extremely conservative, religious and rigid.

The spouse in a relationship in which incest has taken place typically is dependent, non-assertive, and has low self-esteem. The spouse may have married young, thereby moving from one dependent relationship to another.

The Child Sexual Abuse Treatment Program has helped families in Tucson, Arizona since 1981. It offers individual and group counseling as well as a self-help group. The phases of treatment in the Tucson program generally extend for a period of 24 months. The treatment program is composed of four overlapping phases:

- o crisis phase - 0 to 6 months
- o resistance phase - 4 to 9 months
- o growth phase - 6 to 18 months
- o resolution phase -15 to 24 months

Over the past 5 years, 250 families have been involved in this program. There have been only four cases of remolestation and in three of these cases substance abuse was involved. Counseling can be successful in reducing or eliminating child sexual abuse when an intensive, long term treatment program is provided.

MARITAL SEPARATION

Cyrus Stewart
Licensed Marital and Family Therapist

An innovative strategy for working with a couple experiencing severe stress is to structure a separation. When set

up with an agreement, separation can be positive and therapeutic. In fact, a marriage-separation agreement can strengthen a marriage. Dr. Stewart recommends that such a period of separation should last no longer than 6 weeks. Individual sessions are permitted but with other therapists. Conjoint therapy is done only with the separation therapist.

The counselor plays a key role in defining how the couple approach and experience a separation. All too often the client conceives of separation as an opportunity to escape a crisis or to suddenly become an independent decision-maker. The therapist can be the catalyst for changing perceptions and enabling each partner to take responsibility for a problem marriage. Above all, the separation of a husband and wife on a physical, social and emotional basis provides the time and the experience necessary for the redefinition of their relationship.

Four different types of separation are identified and their therapeutic implications are discussed below:

The "In-Home Separated"

During the early stages of marital stress, both partners often withdraw interactionally and emotionally from various aspects of the conflict and thus are described as "in-home separated." This kind of separation seems uncommon because clinicians have not conceived of this condition as a real separation. This situation usually involves intense spousal arguments and feelings of rejection, abandonment and lack of trust are often common.

The "Married Separated"

The "married separated" live apart, but still identify themselves in their marital role and are not interested in examining any of the single options that may be available to them. They have taken a temporary "vacation" from their responsibilities as married persons. Many of the married-separated hope that time, therapy and personal change will enable them to re-negotiate their relationship and re-establish their marriage.

The "Single Separated"

These spouses conceive of themselves as single. While they realize that they are legally married, they behave as though they were single. They seek opportunities to find out if they are still attractive, if they can establish any kind of relationship. and if they have a future beyond their current marriage. The single separated have not necessarily decided to terminate their marriage, and counselors should be aware that overt behavior is not a reliable indicator of a client's plans for the existing marriage.

The "Divorcing Separated"

The "divorcing separated" have arrived at what appears to be a permanent decision to terminate the marital relationship. The divorcing separated are selecting options available to them, having made a decision about the marriage. This group is also beginning to be involved in the more concrete and practical

issues which accompany terminating a marriage (e.g., child custody and financial matters).

A lack of agreement on the type of separation adds stress to the relationship. It is important for the clinician to recognize the distribution of power issues in role conflicts. The **power to maintain** the relationship is exercised by the person who appears to have the least need to maintain the relationship. The counselor should help the couple recognize and explore the balance of power that defines their relationship. Each spouse needs to understand that the time of separation can be an opportunity to examine the major assumptions in the relationship, redefine what each requires in the current relationship, and to work out long-standing frustrations and incongruities.

Counselors should help couples view separation as a normal or natural response to feelings of marital distress and to recognize the various separation options available. A vital element of this phase of therapy is to enable clients to formulate new perspectives and to coordinate the expectations and behavior of the separating spouses.

SUBSTANCE ABUSE

Ann Worth
Private Practice
Dallas, Texas

The most prevalent symptoms of addiction are denial and delusion. This is true for the family as well as the addict. In the initial sessions, counselors must ask pertinent, specific

questions about the use of substances, e.g., how much, how often. This information is essential in identifying families in which addiction is not acknowledged as well as for those families who are seeking treatment for this problem.

Alcoholism is a primary disease and must be treated before therapy really can begin. For the abuser this means abstinence. In addition, family members must quit enabling or prosecuting the abuser, thereby establishing their own type of abstinence from the disease. Every family member is affected by the disease and learns to adapt in a dysfunctional way.

Family members need a tremendous amount of support to recognize the disease and recover, more than a lone counselor can give. The use of AA and AL-ANON are encouraged. The Twelve Step Programs are the most available, most affordable resources to both the family and client. Counselors should attend these meetings as well so they can process their clients' reactions.

It is important to distinguish between a functional family and an addicted family. Addicts leave the family emotionally as they turn more frequently to their drug of choice (substance, work, sex, food, etc.) Their spouses find other ways to get their needs met (e.g., school, children, work, affairs) and a wall of secrecy begins to surround the family. Dysfunctional families are about "doing" instead of "being." Love is conditional and boundaries are missing. Shaming, rigid rules and negative feelings characterize these families.

A functional family operates on unconditional acceptance and meeting such basic needs as food, shelter, time, attention and direction. Functional families give children a sense of belonging, feelings of being loved, a sense of self-worth, and freedom to grow. Reality is encouraged and the individual is valued.

The concept that one is precious, honored, and valued is necessary to overcome the shaming process that has occurred in the family. When caretakers neglect their children, they are acting without shame and the child begins to carry the shame for them. The child would rather believe that the abuse in the family is about them than about their caretaker. This pain of shame and worthlessness can drive a person to alcohol and drugs in order to feel better. Initally, education about this problem is most important for clients to break their denial. One approach is to have them write an autobiography and tell their story when other family members are present. When they get in touch with the dysfunctional pain in the family, the grieving/ healing process can begin.

Teaching clients about sexual, physical, emotional and spiritual boundaries will foster their self esteem in the family as they take care of themselves. For instance, emotional boundaries are that: "What you feel is more about you and your history than what I said or did. And what I feel is more about me and my history than what you said or did." Knowing this helps us focus on **ourselves** and we become actors instead of reactors.

Addicted families need extensive treatment if they are to change from dysfunctional to functional families.

EATING DISORDERS

Pat Halvorson
Counseling Center
North Dakota State University

Pat Neuman
Counselor & Associate Professor
Moorehead State University

Approximately 1 in every 150 high school girls will develop anorexia nervosa. Among these young women, 10-20% will ultimately die from problems related to that disorder. Most eating disorder cases (9 out of 10) occur among females.

Anorexia nervosa is defined as a serious illness of deliberate self-starvation with profound physical and psychological components. Anorexics deny having a problem. At present there is no known simple cause of anorexia nervosa. It appears to be multidimentional occurring through the interaction of a number of factors.

Girls who become anorexic:

- see thinness as a magical solution to life's problems.
- often involve themselves in food activities such as eating rituals, collecting recipes, cooking, or hoarding food.
- have an intense fear of becoming obese, which does not diminish as weight loss progresses.
- have a distorted body image.
- lose 15% or more of their weight.

- experience a cessation of their menstrual periods.
- refuse to maintain a normal weight for their height and body build.

In contrast to anorexia nervosa, bulimia is a disorder characterized by gorging on food. Bulimics tend to maintain their normal weight, although they can be overweight or slightly underweight. They fear not being able to stop eating voluntarily and feel a lot of guilt and shame after a binge. They are aware that their eating pattern is abnormal. There is a high rate of substance abuse and stealing within the bulimic population.

Some mental health professional believe that eating disorders are manifestations of a significant family problem. No single family pattern predominates although some typical characteristics include:

- Parents who tend to exhibit over-involvement in their child(ren);
- Higher than average rates of chemical dependency, obesity and depression in family histories.
- Higher than average rate of incest.

Counselors need to provide education and therapy for the entire family. Some important information for family members includes:

- A explanation of the disorder, what the therapy process will be and that it will be long term.
- Resources for the parents in the form of books, newsletters and support groups.
- That the responsibility of the family members is not to cure the child but rather to back-off and support the recovery process. (A non-coercive approach.)

- That family members can expect to experience a wide variety of emotions such as fear, guilt, anger, and stress.

In providing therapy, the counselor always needs to have medical backup because these disorders are so serious. The therapy process involves changing the eating behavior, enhancing self-esteem, dealing with underlying thoughts and feelings, and developing effective coping skills.

Treatment for both anorexic and bulimic clients should include:

1. Education
2. Self-monitoring regarding food habits
3. Emphasis on reducing binging, purging or starving behavior, and
4. Cognitive restructuring.

In addition to the above, with the anorexic client, counselors need to address their plummeting weight loss. Until anorexic clients are able to attain at least a low normal weight level they will be preoccupied with food and unable to make progress in the four treatment goals listed above.

ADOLESCENT SUICIDE

Dave Capuzzi
President-Elect, AACD
Professor and Coordinator
Counselor Education
Portland State University

Suicide is now the second leading cause of death for adolescents. Between 5.000 and 6,000 adolescents commit suicide each year. Dr. Capuzzi offered these statistics as a reflection of the seriousness of this topic. He emphasized that people need to

lose their fear of this topic. Counselors need to let adolescents hear their comfort with the word suicide. Asking if the person is thinking about suicide does not put the idea in his/her mind.

There are several behaviors in children at risk of suicide:

- They wall off their feelings.
- They are not good communicators.
- They often get depressed.
- They tend to personalize everything.
- They often give away prized posessions.
- Their behavior changes dramatically, e.g., drop out of activities, drop in grades, change in sleeping and eating patterns.

Some personality traits seen in attempters are:

- Prone to make strong commitments to goals and people.
- Poor problem solvers. Quite rigid.
- Not good at managing stress.
- Low in self-esteem.
- Other-directed (dependent).

In order to assess lethality the counselor needs answers to the following questions:

1. Are you thinking about suicide?
2. How will you do it? Where? When?
3. How much do you want to live?
4. How much do you want to die?
5. How often do you feel depressed/suicidal? (Frequency, intensity, duration)

6. Is there anyone or anything to stop you? (This is a key question. Use the significant person in crisis intervention.)

7. Have you ever attempted suicide?

8. What is the probability on a scale of 1-10 that you will go through with it?

The counselor needs to listen for such statements as:

- I'm going to kill myself/commit suicide.
- I wish I were dead.
- I can't go on.
- You won't be seeing me around anymore.
- _____ is going to regret how (he/she) treats me.

In doing crisis counseling, Dr. Capuzzi offered these suggestions:

1. They talk - you accept. Never argue, debate, or make judgmental statements.

2. Reassure the client - "You did the right thing in coming to me."

3. Get information.

4. Tell them you are good at this to give them reassurance.

5. Be direct and assertive in your overall approach. Depressed clients need a treatment modality that is action-oriented and provides hope for the client.

Potential suicides must be helped immediately and these pointers can assist counselors in meeting a clients' needs. Schools, community service agencies and others need to develop intervention and prevention programs if we are to reduce adolescent suicide.

FAMILIES AND UNEMPLOYMENT

Dr. Andrew A. Helwig
Associate Professor
Department of Counseling and Guidance
East Texas State University

Dr. Helwig began his presentation by stating that unemployment is a major source of stress for individuals and their families and is, therefore, of major interest to counselors. Work in our society has value because:

1. It is a means of satisfying one's basic needs (e.g. food, clothing, shelter).
2. It provides self-identity.
3. It organizes our time and provides us with a schedule.

For some people, work also provides a vehicle for keeping potential problems under control. When this coping mechanism is lost the problem areas surface, thereby compounding the individual's stress.

There are a limited number of positive consequences for unemployment; however, these do not generally relate to the chronically unemployed person. Positive consequences may include: relief from getting out of a negative situation; opportunity for a new start, perhaps a new career; opportunity to go back to school or make a geographic move; and/or nurturing untapped skills.

The negative consequences of unemployment, however, usually far outweigh the positive. Through loss of work an individual

commonly experiences stress in five areas of life: (1) financial, (2) psychological, (3) physical, (4) interpersonal, and (5) community/societal.

Financial Consequences - With unemployment comes financial stress in the form of lost wages, salary, and benefits. This loss limits spending for food, clothing, medical expenses, trips, entertainment, vacations, etc. The quality of life diminishes. Long-term unemployment can result in loss of property, vehicles, and harassment by creditors.

Psychological Consequences - With sudden unemployment a person may actually experience the grief process: shock, denial, anger, bargaining, depression and ultimately acceptance. Guilt is often a by-product. During this time there may be a loss of self-esteem, an increase in drinking, smoking, sleeping, fighting, or eating. During a period of unemployment, potential problems often become actual problems.

Physical Consequences - Psychosomatic illness and bodily reactions are common during this period. Headaches, high blood pressure, loss of energy, weight changes, sexual dysfunction and loss of temper are all common reactions to unemployment.

Interpersonal Consequences - Family members are affected by unemployment. Wives of unemployed men have an increase in headaches, depression and anxiety. Children have fewer resources for school, education, fun and extracurricular activities. Communication in marriage often suffers and the divorce rate is higher. Spouse and child abuse rates also increase.

Socially, unemployment carries stigma. Friends and neighbors may perceive the unemployed person negatively. Friends may be reluctant to issue invitations to the family because of embarrassment. Social relationships suffer.

Community/Societal Consequences - Layoffs and shutdowns cost employers and, ultimately, the community. Retail businesses suffer. At the same time there is a commensurate increase in the need for social services. Larger societal costs include: an increase in crime rate, higher hospital admissions, an increase in mental health admissions and a higher suicide rate.

In counseling the unemployed person:

1. Deal with grief.
2. Define the problem or the decisions that need to be made.
3. Help clients analyze their skills, aptitudes, and interests.
4. Give information when needed.
5. Facilitate decision making.
6. Introduce long-term planning.
7. Utilize support groups.
8. Access family resources (e.g. look at how the family can help through support, part-time jobs, cutting spending).
9. Utilize counseling techniques such as guided fantasy, assertiveness training, modeling, and role playing.
10. Utilize referral resources such as employment agencies, Work Incentive Programs, community colleges, AFCD medical assistance, financial counseling, utility assistance, free legal aid, social security, SSI, rehabilitation, and crisis centers.

Unemployment stress impacts millions in the United States each year and is a major contributor to family dysfunction. As counselors deal with unemployment, they are also addressing the health of the basic unit of our culture.

DISABILITY IN THE FAMILY

Paul W. Power
Director
Rehabilitation Counseling Program
University of Maryland

The family plays a pivotal role in the rehabilitation of the disabled person. The family can be an important support system for the patient. Although most helping professionals have been trained to work with the disabled individual on a one-to-one relationship, the family can be utilized effectively to influence a more rapid and lasting rehabilitation of the patient.

Becoming familiar with the family structure, resources, strengths and weaknesses, and dealing with the feelings and the reactions of the family to the patient's disability can provide the counselor with the significant tools to effectively intervene and do a better job in the rehabilitation of the patient. It can, in the final analysis, facilitate the growth of the patient, move the client from trauma to coping styles, from school to a work setting, and from dependency to self-sufficiency.

The chart on the "Role of the Family in Counseling" summarizes how the family can be utilized in the rehabilitation process, ways in which this can be achieved, and what is needed by the counselor.

ROLE OF THE FAMILY IN COUNSELING

HOW THE FAMILY CAN BE UTILIZED	WAYS THE "HOW" CAN BE ACHIEVED	WHAT IS NEEDED BY THE HELPER
Become a support system for the patient	Help family accept disability Help family members accept their feelings	
	Help family understand the psychological factors which affect adjustment	Understand emotional reaction of the patient
	Normalize family life Provide atmosphere of belonging to the patient	Understand nature of family life and emotional reaction to disability/trauma
	Provide information Implement coping strategies Provide security for family members	Have an assessment approach to understand family dynamics
Diminish stress for the patient	Facilitate communication Relate to health-care staff Utilize community support systems Contain disability effects	Have a helping approach that includes: Relationship building Formulation of goals Teaching of family skills
	Enlarge scope of family values Develop family reinforcers	
Facilitate growth of the patient	Develop family competencies Foster confidence among family members	
	Discuss family expectations for each other	Roles of the helper: Assessor Information provider Support Resource person
	Provide information Establish mutual goals Encourage family feedback--praise & encourgement Utilize community support systems	

FAMILIES WITH AGING MEMBERS

Jane E. Myers
Assistant Professor of Guidance and Counseling
and Director of Rehabilitation
Ohio State University

Barbara Shelton
Assistant Professor
Department of Human Resources
East Central Oklahoma University

With the increase in the aging population, both families and social service agencies are presented with a greater number of age-related problems. Of particular concern are the quality of these additional years and the impact of increased longevity on families. Issues often arise in a crisis environment: dependency of the older adult; relocation or institutionalization of the older adult: death of a parent; and, increasingly, suicide of the older adult. For counselors who work with older individuals and for families with older individuals as members, the issues most often are autonomy, abuse, and suicide.

Family Issues

Many families are not concerned with the problems of aging until the death of one parent. Suddenly, the frailties of the surviving parent become more evident. Sometimes family members are shocked to realize the "decline" in the older parent. It is, for some, the first time they have taken a realistic view of their parents.

The issue for the children frequently becomes how to assist the remaining parent: Relocation or living alone? Relocation to the home of a child? A nursing home? A retirement complex? The

underlying question is should they intervene? The surviving parent may be unwilling to relocate and may feel rejected by the children who insist he/she cannot continue to provide self-care. If a nursing home is suggested, the aged parent may feel guilty about becoming dependent and feel rejected if he/she is not offered a place in the home of an adult child. These feelings may contribute significantly to feelings of helplessness, depression, and despair.

When a family discusses relocation of an older adult, the first issue for counseling should be: Is intervention necessary? Is the older person's view of his or her capability realistic? Sometimes families will decide the older individual should not live alone and will disregard the wishes of the older person, despite his/her capabilities.

In some cases, the older person is abused by an adult child. Relationships with children, a belief that children will not harm a parent, and/or an unwillingness to force an adult child out of the home will make the older adult reluctant to terminate the relationship. Counselors are then faced with the prospect of helping the older individual adapt to an abusive situation or going against the wishes of an older client. Other living arrangements are possible if the counselor is well acquainted with the local aging network and the resources available.

Another issue facing the counselor is the suicide of an elderly family member. Suicide as an alternative to a lingering

death is growing as an option in this country. In some cases family members assist the older adult in this effort. Frequently, the issue for the older person is one of self-determination. However, families are caught in the web of grief, guilt, and legal ramifications.

Intervention Strategies

Counselors who work with the elderly or with families who have elderly members should be aware of the myths of aging, the normal social and psychological changes associated with aging, the physical impact of aging, and the resources and options available to older adults. Among the many successful services which have been developed to assist families and older adults, peer group programs have received very positive acceptance. Older adults who are trained for outreach and in the identification of problems and resources are frequently effective in reaching isolated elderly. Counselors need to employ diverse strategies in helping older adults and their families lead meaningful lives.

VALUES TRANSMISSION

Judith Miranti
Chairperson of Education
Our Lady of Holy Cross College
New Orleans, LA

Values about everyday living, cultural heritage, and the moral-ethical-political realm effect human interactions. They are transmitted overtly and covertly. Within a cultural heritage, people learn to appreciate values and to cultivate and

assimilate what has been accumulated over the years in the arts and humanities. In the moral-ethical-political realm, allegiance or devotion to the rightness of legal authority or government is a value which people assimilate. All these are receptive values. In the area of everyday living, one may find critical questioning of things as they are or have been. In the cultural heritage areas, rather than merely maintaining an appreciation of what has been, creation or discovery of something that had not previously existed before is possible. In the moral-ethical-political realm, rejection of reliance on authority, independence of judgment, freedom to take risks or change and, in its most extreme phase, revolution are possible.

The role of the family in transmitting values has been affected as a result of changing societal standards, divorce, single parent families, joint custody and the media. Counselors must be aware of the difference in the quality and time that is currently available to family members due to the changing roles of families, and the multitude of societal demands that have been placed upon families today.

Some people question whether or not values can and should be transmitted within an educational setting. Surveys have found that the public ranks moral education as one of the major components of education. In fact, 98% of educators think they should teach values such as: respect for property; respect for authority; not lying, cheating or physically harming another; and not violating another's civil rights (Batts, 1977).

Schools can contribute to moral education by teaching about the cultural heritage of mankind, by nurturing critical thinking and judgement, by providing and testing ground for values. Indoctrination, values inculcation, values analysis, values clarification, or values commitment are means of transmitting values.

Goals which are shared by most counselors are those which help people become fulfilled and satisfied with the quality of their lives. Counselors' aims are to help people become more constructive group members--in their families, in task groups, in social groups and in society as a whole. Values cannot be ignored in this context.

COMMUNICATING ABOUT SEXUALITY

Kay Stritzel
Early Childhood Consultant
Family Development Center

Sexuality is much more than intercourse. It includes feelings about oneself, gender roles, and self-image. Thus, communication about sexuality begins in infancy. By age five attitudes and values about sex are firmly implanted.

In fostering a positive attitude about one's sexuality there are several important components. Feelings of empowerment and physical capacity help children accept themselves and others. They need to develop feelings of independence so they feel they have some control over their own bodies. Giving them the opportunity to have other-sex friends is important in

fostering their understanding of self and others. Helping them learn that they are responsible for what they do facilitates their limit setting abilities.

Several points can guide parents in their discussions about sexuality. First, understanding the ages and stages of development is helpful for parents. Second, children need to know that they can ask their parents questions. Third, parents need to explain that they may not know the answers or be comfortable with the subject, but that they will always try to be helpful. Fourth, people have different attitudes about sexuality. Fifth. sexuality is a topic, like many others. that can be discussed many times.

Guidelines for parents' discussions include:

- Use correct language for body parts and sex.
- Never laugh at or shame a child for having a question.
- Validate a child's questions.
- Take time out when asked a question or set up a time to discuss it.

All these things will help make parents more "askable" parents and will enhance communication about sex.

Encouraging children to approach their parents with questions about sexuality and relationships helps parents too. They get an opportunity to share their values and experiences with their children and they build a more open and trusting relationship with them.

SINGLE PARENT FAMILIES

Rick Bruhn
Clinical Director
Marriage and Family Therapy Program
St. Mary's University

Single parent families are created through divorce, death of a parent, or pregnancy where the child is with only one parent. Dr. Bruhn asked the participants to identify problems of single parent families and then focused on several important issues listed. Limited income and time pressures on the parent who must work, care for the child(ren) and squeeze in his/her own social activities, all without the help of a spouse, are major stressors. Isolation from support networks, friends and extended family because of time pressures adds further stress. Dealing with the child(ren)'s reactions to divorce, the death of a parent, or peer criticism because only one parent is present can be difficult. Parents must also deal with their feelings of loss, anger, resentment, guilt, pressure and isolation. Single fathers and mothers face similar yet different concerns, while custodial or non-custodial parent status carries with it different responsibilities evoking diverse emotional responses.

Counselor intervention with single parent families may differ depending on the family's situation and the amount of time elapsed since the loss of a parent. Right after a divorce the counselor should be supportive and not confrontive, encouraging the client to practice telling their divorce story but making it shorter and shorter. Clients may experience a grief process

similar to the one identified by Dr. Kubler-Ross. Grief work may be done individually or in support groups.

Techniques such as relaxation and guided imagery can help develop ego strength and present metaphors for coping. Clients often need special help in learning to relax and decrease tension before they can deal with some of their issues.

Counseling can be helpful in developing time management skills, career options, child care options, parenting skills, communication skills and specific information about the reactions of children to the loss of a parent. Group counseling can be effective when clients are past the grieving stage and ready to build their interpersonal skills. Counselors must look at interpersonal relationships, including patterns of relating between the parent and the child(ren), the parent and an ex-spouse, the parent and the extended family, and the family's relationship with schools, social agencies and other groups. Counselors may also help their clients examine patterns learned in their family of origin that they are replicating in current relationships. By addressing these issues, clinicians can assist all family members in adapting to living in a single parent household.

CREDENTIALING ISSUES FOR MARRIAGE AND FAMILY COUNSELORS

David Brooks
President-Elect, AMHCA
Assistant Professor
Department of Counseling and Guidance
Syracuse University

Rory Madden
President, AMHCA

Richard Wilmarth
Past President, AMHCA
Director, Opelika Counseling Center

The purpose of this session was to explore similarities and differences in the training and credentialing of counselors specializing in marriage and family work according to the standards of various professional organizations. The training standards of the American Association for Counseling and Development (AACD) and the American Association of Marriage and Family Therapy (AAMFT) were highlighted. The second segment of the presentation compared various approaches to counselor supervision. The session concluded with a comparison of certification and licensure options open to professional counselors with particular attention to the marriage and family counseling specialization.

Dr. Brooks began by asking "Who can do marriage and family counseling? Who says they can do it? How are marriage and family counselors trained and credentialed?" He stated that participants would have answers to these questions when the session concluded.

Dr. Brooks compared the training standards of AACD and AAMFT. The common core of AACD standards consists of studies in the following areas: (1) human growth and development; (2) social and cultural foundations; (3) the helping relationship; (4) group dynamics and group counseling; (5) lifestyles and career development; (6) appraisal of the individual; (7) research and evaluation; and (8) professional orientation. The AACD standards also require coursework in environmental and specialized studies appropriate for the setting for which the aspiring counselor is preparing and supervised experience in laboratory, practicum, and/or internship. The standards require that an approved program of study consist of at least 48 semester credits.

The AAMFT standards require 45 semester credits distributed among the following areas: (1) human development; (2) marital and family studies; (3) marital and family therapy; (4) professional studies; (5) supervised clincial work; (6) research methodology. Eligibility for clinical membership in AAMFT includes possession of a graduate degree that incorporates the above areas in one of the following disciplines: marriage and family therapy, social work, nursing, clincial or counseling psychology, medicine, or an allied field. (Counseling and guidance is not listed as an allied field.)

Dr. Brooks concluded his portion of the session by pointing out the similarities between the two organizations' training standards. "It is unfortunate that frequent political disputes,

particularly those involving state licensure bills, have led to an estrangement based on turf issues between the two groups that benefits no one," he stated.

Mr. Madden began by stating that the goals of supervision for mental health counselors working in marriage and family settings has historically fallen into two areas:

1. Cognitively based skills, e.g., Minuchin's structural concepts and Haley's strategic therapy.
2. Personal therapist growth aspects, e.g., Whitaker's experimental therories and Satir's growth-oriented ideas.

Specific techniques of supervision currently used in the field were highlighted including audio tapes, videotapes, and supervisory viewing of the counseling session.

Mr. Madden stated that family counseling must be viewed from a systems approach and that students must receive specific training in marriage and family therapy. He concluded with two quotes from marriage and family literature:

> The real proof of the pudding is not simply whether students' behaviors come to resemble more closely those which the supervisor believes to be therapeutic, but whether the clients do, in fact, improve.
> --Matarazzo (1971)

> The goal of supervision in marriage and family therapy is to develop the clinician who can do therapy independently. Ultimately, the fully competent counselor becomes his/her own supervisor.
> --Mead and Crane (1978)

Dr. Richard Wilmarth gave a brief history of the credentialing of marriage and family therapists and the development of

related professional associations. The following organizations were identified in the presentation:

1. In 1942, the American Association for Marriage and Family Therapy was established;

2. In 1958, the Academy of Psychologists in Marital, Sex and Family Therapy was established;

3. In 1974, the American Association of Sex Educators, Counselors and Therapists was established;

4. In 1978, the American Family Therapy Association was established; and

5. In 1979, the National Academy of Certified Clinical Mental Health Counselors was established.

Dr. Wilmarth discussed the various procedures and requirements of the related organizations regarding certification. In his concluding remarks, he stressed that there is still much controversy in the field of marriage and family counseling. The established mental health professions have argued that marriage and family therapy is a specific approach in the delivery of mental health services vis-a-vis psychotherapy, while the marriage and family community contends that there is nothing in the established credentialing procedure of the mental health professions that ensures adequate training in family therapy." Dr. Wilmarth noted that the credentialing issue in marriage and family therapy is still unresolved and will continue to be a controversial subject in the future.

STEPFAMILIES

Frank Williams
Family Life Specialist
University of Arizonia

Lynn O'Hern
Author

"Stepfamilies" are families in which either spouse has a child from a previous marriage, regardless of whether the child lives with this couple. An estimated 40%-50% of remarriages fail, so counselors see many couples and families who have special concerns that result from being a stepfamily.

All stepfamilies are born of loss. A major issue is how the different family members deal with this loss. Frequently, it is difficult for the members to interact with each other without their feelings about the previous family system and its members interfering with their current relationships. Their relationships with the other biological parent can influence how they interrelate within the stepfamily. Because the parent-child bond predates the marriage bond, it is generally stronger. Loyalty may be a major concern to some stepfamily members, even in cases where the other biological parent died.

Each person brings his/her own complex background to the family as well as attitudes and feelings about being a member of a stepfamily. Counselors need to assess these attitudes and feelings and a genogram may be particularly helpful in understanding past and present family relationships.

Stepfamily children may live in two households, moving back and forth between both biological parents. In many cases, the children readily handle this change while the adults have some difficulty. Another factor that distinguishes between nuclear families and stepfamilies is that no legal relationship exists between the stepparents and the stepchildren.

Counselor Issues

Counselors need to be aware of their own values and beliefs concerning divorce, living together arrangements, remarriage, and the possible impact of these events on children. The key element in a functional stepfamily is the couple, and counselors should not allow the entire focus of therapy to be guided to the misbehavior of the "problem" child. In addition to understanding the dynamics and complexities of stepfamilies, counselors need to be able to tolerate ambiguity and chaos. In short, they must not only educate the stepfamily, they must model patience and understanding as the new family members become integrated.

Counselors who work with stepfamilies need to give each member:

1. Permission to share, care, like/dislike, love/not love the stepparent or the children;
2. Information about skills in working with each other; and
3. Options to help each one understand and deal with split loyalties.

Goal Setting

In working with stepfamilies, counselors need to help members formulate specific goals, such as:

1. Mourning and acceptance of their own personal loss.
2. Establishment and negotiation of new traditions and rituals.
3. Formation of new alliances and maintenance of old.
4. Integration and restructuring of the family form.
5. Individuation and autonomy of each family member.

Stepfamilies present many challeges and potential rewards for counselors.

SEX ROLES

James Winfrey
Professor of Counseling
San Francisco State University

Sex role problems are evident in many counseling situations. Studies across cultures have found that men's roles have been more instrumental and "thing" oriented while women's roles are more expressive and "feeling" oriented. In short, these roles reflect a dichotomy between **doing** and **being**.

The father role is the superego in the family of law, power and work while the mother role is a relationship role. A dominant male theme is competition and roles in our society often have this emphasis. A male's first role model is usually his father. His interactions frequently are activity oriented with a focus on helping the son compete and do things better. In contrast, female role models emphasize being together and relating to people rather than doing something. Research suggests that these sex roles may be established as early as 18 months.

Sex roles determine occupations, dress, speech, parenting and attitudes. The male role continually provides the power and the female does the providing of services for this power. Religion often reinforces traditional sex roles.

Rigid sex roles restrict people's feelings and behavior, especially among males. Women may have wide latitude in their sex-typed behavior but men are generally more restricted in our society. Rigid sex roles result in restricted personal spontaneity and freedom for both males and females.

One implication of these roles in therapy is that the females will initially ask for the help but terminate when things get better because "that is all they deserve." Males are often harder to hook in therapy but once they are, they tend to stay longer in order to "do it right."

A major counseling goal may be to help people understand the origins and impact of these attitudes. Understanding these forces is the first step in giving people permission to be themselves.

MARRIAGE AND FAMILY ASSESSMENT INSTRUMENTS

Norman Fredman
Coordinator
Counselor Education Programs
Queens College

A suprisingly large number of inventories have been developed to measure family relations. Straus and Brown list 813 inventories published from the late 1930s to 1974. Doctoral theses, academic research, and journal articles have been the main source of inventories until recently. Inventory use by

clinicians is increasing with the professionalization of family therapy.

The psychometric problems troubling personality inventories afflict family inventories as well. If the reliability of a cohesion subscale is .80 or below, for example, it could signify that husband and wife may not mean the same thing by "enmeshment." Family measurement has the additional problem of trying to measure a system, not an individual.

Popularly used personality inventories can indicate the need for family therapy. Scale 4 on the MMPI (in combination with other scales) often reveals problems in family relations. Projective techniques have rarely been used, although Dr. Fredman showed how some clinicians have already compared couple responses to the Draw-a-Person before, during, and after therapy. Even such "non-family" inventories as the Myers-Briggs Type Indicator and the Productivity Environmental Preference Survey can be helpful in family therapy. These tools can demonstrate that, in some cases, one's spouse is different, rather than contrary.

The original marriage and family inventory was developed by Lewis Terman and modified by Locke-Wallace in 1959. Their work is still widely used, but by researchers rather than by clinicians. This instrument is too complex to grade and too global to be of much use. While the scoring problem can be corrected easily, clients tend to give socially desirable rather than honest responses, negating the value of this inventory.

Two recent systems-oriented inventories were discussed: FACES by Olson and Associates and IFF by Lowman. FACES is based on a circumplex model that sees virtue in moderation in family adaptability and cohesion. Differences between family member's perceptions of the real and ideal family situation provide material for insight and communication. IFF reveals alliances and scapegoating. Both can be important tools to clinicians as well as researchers.

SUMMARY OF AACD SURVEY ON TRAINING NEEDS RELATED TO CHILDREN, YOUTH AND FAMILIES

The Committee on Children, Youth and Families developed a survey to ascertain the training experience and needs of AACD members in family counseling. The survey was field tested by distributing it at the Families Conference in San Antonio, February 1-3, 1986. Sixty-six persons completed the survey. All but five of the respondents were members of AACD. A summary of the survey follows:

Of the 66 respondents participating in the study, 60% reported that family counseling coursework was not a part of their formal educational training. Participants reported gaining knowledge of family counseling through workshops, books, in-service training, videotapes, supervision, professional journals and formal coursework.

The major areas cited for additional training and/or information were single-parent families, substance abuse, children

of alcoholics, stepfamilies, parenting skills, gender roles, and family therapy and techniques.

Of the 31 topics listed, 18 were deemed "very important" to the training of professional counselors by at least 60% of the respondents. Among the most often cited areas were:

- child abuse
- sexual abuse
- domestic violence
- suicide
- depression
- teenage depression
- motivational difficulties
- substance abuse
- death and dying
- dynamics of the spousal relationship
- single parent families
- latchkey children
- healthy family functioning
- family roles and adult responsibilities
- teen pregnancy
- family communication
- stepfamilies
- parenting skills

The majority of respondents (68%) held masters degrees and listed "counselor" as their occupation. The work settings cited were divided almost equally among public school, private practice and higher education. The majority (82%) reported being in the counseling profession for more than five years.

Most of the persons who completed the survey reported that much of their client contact was individual counseling, although group, couple and family counseling were also conducted. The majority (80%) stated that they did spend time working with clients on family-related issues.

This survey has been revised and will be used to survey a larger audience of counselors. The Committee on Children, Youth, and Families will use this information in meeting their mission to identify the marriage and family training needs of counselors and to assist AACD in planning future activities.

BIBLIOGRAPHY

Aldous, J. (1978). Family careers: Developmental change in families. New York: Wiley.

Amundson, N.E., & Borgen, W.A. (1982). The dynamics of unemployment: Job loss and job search. The Personnel and Guidance Journal, 60, 562-564.

Aponte, H. (1982). Foreword in Ethnicity and Family Therapy. (pp.xiii-xiv). Edited by M. McGoldrick, J. K. Pearce & J. Giordano (Eds). New York: The Guilford Press.

Black, C. (1982). It Will Never Happen To Me. Denver, CO: M.A.C. Printing and Publishing.

Block, M.R. & Sinnott, J.D. (Eds.). (1979). The Battered Elder Syndrome. College Park, Maryland: University of Maryland Center on Aging.

Brandy, D. & May, P.A. (1983). Demographic and Epidemeologic Transition among the navajo indians. Social Biology, 30(1), 1-16.

Bruch, H. (1973). Eating Disorders, Obesity and Anorexia. New York: Basic Books, Inc.

Burgess, A. W., Holmstrom, L.L., Groth, A.N. & Sgroi, S. M. (1978). Sexual Assault of Children and Adolescents. Lexington, MA: Lexington Books.

Butler, S. (1979). Conspiracy of Silence: The Trauma of Incest. New York: Bantam Books.

Butts, R. F., Pechinough, D.H., Kirschenbaum, H. (1977). The School's Role as Moral Authority. Washington, D.C.: Association for Supervision and Curriculum Development.

Calderone, M. & Ramey, J. (1982). Talking With Your Child About Sex. New York: Ballantine.

Cook, D. and Ferriton, D. (1985) Related needs of school children with severe physical disabilities. Journal of Applied Rehabilitation Counseling, 16, 52-53.

Davis, P.A. (1983). Suicidal Adolescents. Springfield, Illinois: Charles C. Thomas.

Duhl, B.S. (1983). From the Inside Out and Other Metaphors. Creative and Integrative Approaches to Training in Systems Thinking. New York: Brunner/Mazel.

Duhl, B.S., and Duhl, F.J. (1981). Integrative family therapy. In A. Gurman & D. Kniskern (Eds), Handbook of Family Therapy in A. Gurman, and D. Kniskern, New York: Brunner/Mazel.

Duhl, F.J., Kantor, D., and Duhl, B.S. (1981). Learning, space and action in family therapy: a primer of sculpture. In D. Bloch (Ed.), Techniques of Family Psychotherapy, New York: Grune and Stratton.

Family Service America, (1984). The State of Families, 1984-85. New York: Author.

Filsinger, E. and Lewis, R. (Eds.) (1983). Assessing Marriage: New Behavior Approaches. Beverly Hills, CA: Sage.

Filsinger, E. (Ed.) (1983). Marriage and Family Assessment. Beverly Hills, CA: Sage.

Finklehor, D. (1979). Sexually Victimized Children. New York: Free Press.

Finley, M.H., & Lee, A.T. (1981). The terminated executive: It's like dying. Personnel and Guidance Journal, 59, 382-384.

Fraenkel, J.R. (1981). A comprehensive program of values education is needed. Education Digest, 46(8): 2-5.

Fredman, N. and Sherman, R. (in press). Handbook of Inventories in Marriage and Family Therapy. New York: Brunner/Mazel.

Ganikos, M.L. (Ed.). (1979). Counseling the aged: A training syllabus for educators. Alexandria, VA: AACD.

Ganikos, M.L., Grady, K., Olson, J., Blake, R., Fitzgerald, P. & Lawrence, P. (Eds.) (1979). A handbook for conducting workshops on the counseling needs of older people. Alexandria, VA: AACD.

Garfinkel, P.E., and Garner, D.M. (1982). Anorexia Nervosa: A Multidimentional Perspective, New York: Brunner/Mazel.

Garner, D.M., Garfinkel, P.E., and Bemis, K.M. (1982). A multidimensional psychotherapy for anorexia nervosa. International Journal of Eating Disorders. 1: 3-46.

Garner, D.M., Garfinkel, P.E. (1979). Eating attitudes test (EAT). Psychological Medicine, 9: 273-279.

Giaretto, H. (1976). Humanistic treatment of father-daughter incest. In R.E. Hefler (Ed.), Child Abuse and Neglect. Cambridge, MA: Ballinger Publications.

Gottman, J., Notarius, C., Gonso, J., Markman, H. (1976). A couple's guide to communication. Champaign, IL: Research Press.

Haley, J. (1976). Problem-Solving Therapy: New Strategies for Effective Family Therapy. San Francisco: Jossey-Bass.

Hansen, L.S. (1985). Work-family linkages: Neglected factor in career guidance across cultures. The Vocational Guidance Quarterly, 33, 202-212.

Hatlon, C.L., Valente, S.M., & Rink, A. (1977). Suicide: Assessment and Intervention. New York: Appleton-Century-Crofts.

Hohenshil, T.H. (1979). Counseling handicapped persons and their families. The Personnel and Guidance Journal, 58 (4), 213.

Husain, S.A. and Vandiver, T. (1984). Suicide in Children and Adolescents. New York: S.P. Medical & Scientific Books.

Johnson, Vernon E. (1980). I'll Quit Tomorrow. (Rev.ed.). New York: Harper and Row.

Jones, W. H. (1979). Grief and Involuntary Career Change: Its Implications for Counseling. Vocational Guidance Quarterly, 27, 196-201.

Kinoy, B., Miller, E., Atchley, J. (1984). When Will We Laugh Again? Living and Dealing with Anorexia and Bulimia. New York: Columbia University Press.

Levenkron, S. (1982). Treating and Overcoming Anorexia Nervosa. New York: Charles Scribner.

Liem, R., & Rayman, P. (1982). Health and Social Costs of Unemployment. American Psychologist, 37, 1116-1123.

Longo, D. C. & Bond, L. (1984). Families of the Handicapped Child: Research and Practice. Family Relations. 33 (1), 57-65.

Macklin, E. (1980). Nontraditional family forms: a decade of research. Journal of Marriage and the Family. 42(4), 175-192.

Matarazzo, M. (1971). An Outline of Marriage and Family Therapy. Dubuque, IA: William C. Brown.

Mead, C. and Crane, W. (1978). Concepts in Family Therapy. New York: Dell Publishing Company.

Miller, J.V. (1984). The family-career connection: A new framework for career development. Columbus, OH: The National Center for Research in Vocational Education, The Ohio State University.

Minuchin, S. (1974). Families and Family Therapy. Cambridge, MA: Harvard University Press.

Minuchin, S. (1978). Psychosomatic Families, Harvard University Press.

Monks, R., (1980). Values education in the 1980s. Education Digest, 46(2): 44-45.

Myers, J.E., Finnerty-Fried, P.F., & Graves, C. (Eds.) (1981). Counseling older persons. Volume I. Basic helping skills for service providers. Alexandria, VA: AACD.

Myers, J.E. & Ganikos, M.L. (Eds.). (1981). Counseling older persons. Volume II. Basic helping skills for service provider. Alexandria, VA: AACD.

Myers, J.E. (Ed.). (1981). Counseling older persons. Volume III. A trainers's manual for basic helping skills. Alexandria, VA: AACD.

Neuman, P. and Halvorson, P. (1983). Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists. New York: Van Nostrand Reinhold.

Okun, B.F. (1984). How to help your child choose a career. New York: M. Evans.

Okun, B. and Gladding, S. (Eds.) (1983). Issues in Training Marriage and Family Therapists. Ann Arbor, Michigan: ERIC Counseling and Personnel Services Clearinghouse.

Olson, D., McCubbin, H., Barnes, H., Larsen, A., Maxen, M. & Wilson, M. (1982). Family Inventories. St. Paul, MN: Family Social Science.

Osgood, N.J. (1985). Suicide in the Elderly. Rockville, Maryland: Aspen Systems Corp.

Palmer, R.L. (1980). Anorexia Nervosa: A Guide for Sufferers and Their Families. New York: Pelican Books.

Pogrebin, L. (1980). Growing Up Free. New York: McGraw-Hill.

Powell, L.S. & Courtice, K. (1983). Alzheimer's Disease: A Guide for Families. Reading, MA: Addison-Wesley Publishing.

Pryor, R. G. L., & Ward, R. T. (1985). Unemployment: What counselors can do about it. Journal of Employment Counseling, 22, 3-17.

Pushur, C.C. (1983). Developing respite care: a support service for families with disabled members. Family Relations. 32, 13-20.

Satir, V. (1964). Conjoint Family Therapy. Palo Alto: Science and Behavior Books, Inc.

Satir, V. (1972). Peoplemaking. Palo Alto, Calif: Science and Behavior Books, Inc.

Sheffield, M. (1979). Where Do Babies Come From? New York: Knopf.

Shiffron, R., Dye, A., & Shiffron, G. (1983). Implications for counseling the unemployed in a recessionary economy. The Personnel and Guidance Journal, 61, 527-529.

Sprung, Barbara (Ed.) (1978). Perspectives on Non-Sexist Early Childhood Education. New York: Teachers College Press.

Stokes, G., & Cochrane, R. (1984). A study of the psychological effects of redundancy and unemployment. Journal of Occupational Psychology, 57, 309-322.

Straus, M. and Brown, B. (1978). Family Measurement Techniques. (rev.ed.). Minneapolis, MN: University of Minnesota Press.

Sue, D.W. (1981). The politics of Counseling. In D.W. Sue (Ed.) Counseling the Culturally Different (pp 3-21). New York: John Wiley and Sons.

Summit, R. (1978). Sexual Child Abuse, the Psychotherapist, and the Team Concept in Dealing with Sexual Abuse. Chicago: National Committee for Prevention of Child Abuse.

Tavormina, J.B., Boll, T.J., Dunn, N.J., Luscomb, R.L., & Taylor, J. R. (1980). Psychosocial effects on parents of raising a physically handicapped child. Journal of Abnormal Child Psychology. 9 (1), 121-131.

Veevers, J.E. (1979). Voluntary childlessness: A review of issues and evidence. Marriage and Family Reviews. 2 (Summer), 1-26.

Voydanoff, P. (Ed.). (1984). Work and family: Changing roles of men and women. Palo Alto, CA: Mayfield.

Watzlawick, P. and Weakland, J. H. (Eds.). 1977. The Interactional View. New York: W. W. Norton and Company.

Wegscheider, S. (1980). Another Chance: Hope and Health for Alcoholic Families. Palo Alto CA: Science and Behavior Books, Inc.

Whanger, A.D. & Myers, A.C. (1984). Mental Health Assessment and Therapeutic Intervention with Older Adults. Rockville, Maryland: Aspen Systems Corp.

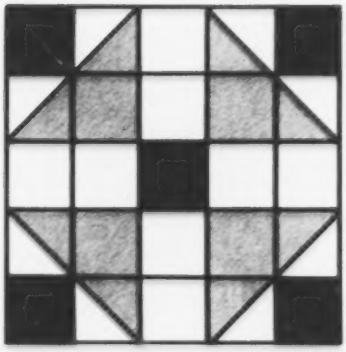
Whitaker, C. A. (1977). Process techniques of family therapy. Interaction. 1: 4-19.

Woititz, Janet G. (1983). Adult Children of Alcoholics. Pompano Beach, FL: Health Communications, Inc.

Zarit, S.H., Orr N.K. & Zarit, J.M. (1984). Working with Families of Dementia Victims: A Treatment Manual Vol. 4 Grant No. 90-AT-2167). Washington, D.C.: Administration on Aging.

Appendix A

Conference Proceedings

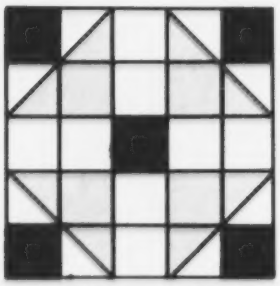


Quilt pattern: "Grandma's family"

Families:
An Expanding Role for Professional Counselors

February 1–3, 1986

The American Association for Counseling and Development



Quilt pattern "Grandma's Family"

Families:
An Expanding Role for Professional Counselors
February 1-3, 1986

PROGRAM

SATURDAY, FEBRUARY 1, 1986

		Room
4:00 p.m. - 6:30 p.m.	**Registration**	Mezzanine
5:30 p.m. - 6:30 p.m.	**Hospitality Hour**	Terrace
6:30 p.m. - 7:30 p.m.	**Dinner**	Yellow Rose
7:30 p.m. - 9:30 p.m.	Opening Remarks: Patrick J. McDonough, AACD Executive Director	
	Economic, Social and Political Influences on Families	Crystal

•Dr. Lynda Henley Walters, Associate Dean for Instruction and Research and Associate Professor of Child and Family Development, College of Home Economics, University of Georgia.

Lynda Henley Walters

Family Structures and Stresses: A Counseling Perspective

•Dr. Edwin Herr, Professor and Head, Division of Counseling and Educational Psychology, The Pennsylvania State University; past president of AACD and a former NVGA and ACES President.

Presiding: Rose Cooper, AACD President

Edwin Herr

SUNDAY, FEBRUARY 2, 1986

8:00 a.m. - 9:30 a.m.	**Cultural Diversity among American Families**	Crystal

•Panelists: Michael S. Nystul, Associate Professor, Eastern New Mexico University.
Augustine Baron, Jr., Director of Training, University of Texas Counseling and Mental Health Center.
Dorothy Jenkins, Director of Guidance and Counseling in the District of Columbia Public Schools and ASCA President.

Presiding: Wanda Lipscomb, AMCD President

		Room
9:30 a.m. - 9:45 a.m.	**Break**	
9:45 a.m. - 12:15 p.m.	**Working with Families: A Demonstration** •Dr. Bunny Duhl, Co-Director, Boston Family Institute; Trainer in systems thinking and therapy. Presiding: Dave Capuzzi, AACD President-Elect	Crystal

Bunny Duhl

12:30 p.m. - 1:45 p.m.	**Round Table Luncheon**	Yellow Rose
2:00 p.m. - 3:30 p.m. and 3:45 p.m. - 5:15 p.m.	**Family Problems and Effective Approaches** Eight concurrent sessions will be offered twice for 90 minutes each. Counseling practitioners who are experienced in working with these problems within a family context will discuss the problem and explain their approaches. Please select two sessions from the following list:	
	•**Child Sexual Abuse**, Bob Rencken, Executive Director, Arizona Counselors Association.	Mahncke
	•**Divorce**, Cyrus Stewart, Licensed marital and family therapist.	Baker
	•**Substance Abuse**, Ann Worth, private practice, Dallas.	Lee
	•**Eating Disorders**, Pat Halvorson, Assistant Professor, Counseling Center, North Dakota State University; Pat Neuman, Counselor, Counseling Center, Moorehead University.	Alamo
	•**Suicide**, Dave Capuzzi, President-Elect, AACD; Professor and Coordinator, Counselor Education, Portland State University.	Traildrivers
	•**Unemployment**, Andrew Helwig, Associate Professor, Counseling and Guidance Department, East Texas State University.	Lincoln
	•**Disability in the Family**, Paul Power, Director, Rehabilitation Counseling Program, University of Maryland.	Frontier
	•**Families with Aging Members**, Jane Myers, Assistant Professor of Guidance and Counseling and Director of Rehabilitation, Ohio University; Barbara Shelton, Assistant Professor, Department of Human Resources, East Central Oklahoma University.	Vance
	Dinner on own	

MONDAY, FEBRUARY 3, 1986

		Room
8:30 a.m. - 9:30 a.m.	**The Impact of Work on Families** •Dr. Juliet Miller, Associate Director for Information Systems and Director of the ERIC Clearinghouse on Adult, Career and Vocational Education, The Ohio State University. Presiding: Sharon J. Alexander, Director of Professional Development and Research, AACD	Crystal

Juliet Miller

9:30 a.m. - 10:30 a.m. and 10:45 a.m. - 11:45 a.m.	**Family Development: Common Stages and Facilitative Programs** Eight concurrent sessions will be offered twice for 60 minutes each. They will feature counselors who have developed strategies for fostering positive development on diverse family issues. Please select two sessions from the following list:	
	•**Values Transmissions**, Judith Miranti, Chairperson of Education, Our Lady of Holy Cross Hospital.	Mahncke

		Room
	•**Communicating about Sex,** Kay Stritzel, Early Childhood Consultant, Family Development Center.	Baker
	•**Single Parent Families,** Rick Bruhn, Clinical Director, Marriage and Family Therapy Program, St. Mary's University.	Lee
	•**Credentialing Issues for Marriage and Family Counselors,** David Brooks, President-Elect, AMHCA, Syracuse University; Rory Madden, President, AMHCA.	Alamo
	•**Child Care,** Edward Wilson, Clinical Director, Peoples Place, Milford, Delaware.	Lincoln
	•**Stepfamilies,** Frank Williams, Family Life Specialist, Cooperative Extension Service, University of Arizona; Lynn O'Hern, author on marriage counseling.	Frontier
	•**Sex Roles,** James Winfrey, Professor of Counseling, San Francisco State University.	Vance
	•**Marriage and Family Assessment Instruments,** Norman Fredman, Coordinator, Counselor Education Programs, Queens College.	Crystal
11:45 a.m. - 12:15 p.m.	**Case Studies for your consideration** •Dr. Patricia Ponder, Associate Professor, Department of Counseling and Guidance, East Texas State University and Clinical Director of the Department of Marriage and Family Therapy. Presiding: Rory Madden, President, AMHCA.	Crystal
12:30 p.m. - 2:00 p.m.	**Lunch and discussion of case studies**	Yellow Rose
2:15 p.m. - 3:30 p.m.	**Recommended Treatment Approaches for Case Studies** •One "reporter" from each table will be asked to make comments on key issues that they considered and their recommended treatment approaches. Dr. Patricia Ponder will answer questions and make comments on the ideas discussed.	Crystal
3:30 p.m. - 3:45 p.m.	**Concluding Remarks:** Dr. Rose Cooper, President, AACD	Crystal

Pat Ponder

Sponsored by:

American Association for Counseling and Development

in affiliation with

- •American College Personnel Association
- •American Mental Health Counselors Association
- •American Rehabilitation Counseling Association
- •American School Counselor Association
- •Association for Counselor Education and Supervision
- •Association for Humanistic Education and Development
- •Association for Measurement and Evaluation in Counseling and Development
- •Association for Multicultural Counseling and Development
- •Association for Religious and Values Issues in Counseling
- •Association for Specialists in Group Work
- •Midwest Regional Branch Assembly
- •National Career Development Association
- •Southern Regional Branch Assembly

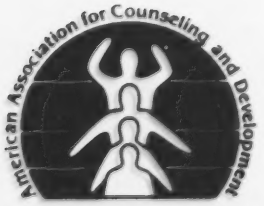
This conference is supported, in part, by a gift from the Shell Companies Foundation.

The American Association for Counseling and Development is a private, non-profit organization dedicated to the growth and enhancement of the counseling and human development profession. Founded in 1952, AACD is a membership association with more than 49,000 members in the United States and 50 foreign countries. It provides leadership training, continuing education opportunities and advocacy services for its members.

AACD has been instrumental in setting standards for the counseling profession through its efforts in accreditation, licensure and national certification. It also represents members' interests with other professional associations, before Congress and with federal agencies.

AACD members work in education settings from pre-school through higher education, in community organizations, correctional institutions, employment agencies, rehabilitation programs, government, business, industry, research facilities and private practice. Association members participate in regional activities and in national divisions organized around specific interest areas. Each division publishes a journal and provides opportunities for professional development.

AACD and its members are committed to the continuing development of the counseling profession.



5999 Stevenson Avenue, Alexandria, Virginia 22304 · 703/823-9800